Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004017	A. BUILDING _____ B. WING _____	C 06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTINA HOUSE	1435 CHRISTIAN BLVD FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00109026. Complaint IN00109026 - Unsubstantiated due to lack of evidence. Survey date: June 26, 2012 Facility number: 004017 Provider number: 004017 AIM number: N/A Survey team: Joyce Hofmann, RN Census bed type: Residential: 58 Total: 58 Census payor type: Other: 58 Total: 58 Sample: 3 Christina House was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00109026. Quality review 6/27/12 by Suzanne Williams, RN	R 000		